STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

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F000000	This visit was for the Investigation of Complaint IN00158834. Complaint IN00158834 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: November 10 and 12, 2014 Facility number: 000230 Provider number: 155524 AIM number: 100275000 Survey team: Susan Worsham, RN- TC Census bed type: SNF: 10 SNF/NF: 123 Total: 133 Census payor type: Medicare: 18 Medicaid: 89 Other: 26 Total: 133 Sample: 03 This deficiency reflects State findings cited in accordance with 410 IAC	F000000	By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the right to contest the findingsor allegations as part of any proceedings and submit these responses pursuantto our regulatory obligations. Thefacility request the plan of correction be considered our allegation ofcompliance effective 10-03-14 to the state findings of the complaint surveyconducted on November 10th and 12th, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	16.2-3.1. Quality review completed on November 21, 2014; by Kimberly Perigo, RN.			
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure the front sliding doors of the facility would immediately lock if a resident with a wanderguard system in place were to get close to the door for 1 in 3 residents reviewed for elopement risk, which resulted in a resident elopement. (Resident#A). Findings include: Review on 11/10/14 at 11:30 a.m., of Resident #A's closed clinical record indicated Resident #A's diagnoses included, but were not limited to: combativeness, depression and dementia. Resident #A's BIMS (Brief Initial Mental Status) dated 10/3/14, was a 6 (severely cognitively impaired).	F000323	The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A was immediately placed on one on one supervision until the defective door was repaired. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* the facility immediately called the vendor to come and repair the door. The facility placed the receptionist in charge of visually monitoring the door to ensure no other resident at risk for elopement left the facility. The vendor came to the facility within four hours of the event and temporarily repaired the door so that the door would alarm when emergency egress was	11/12/2014

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	Resident #A's nursing notes dated 9/26/14, indicated at approximately 5:00 p.m. Resident #A's daughter came into the facility to ask the nurse to come out to the car and assist the family in getting Resident #A out of the car, as he was refusing to come into the facility. Resident #A's daughter had indicated to the nurse the family had given Resident #A an extra Xanax (an anti-anxiety drug used for anxiety and panic disorders) tonight to help. Continuation of above nursing notes indicated the nurse tried several non-invasive tactics such as offering of coffee and food. However, according to the nurses notes, Resident #A still refused to get out of the car and go into the facility. Continuation of the above nursing notes also indicated the family asked the nurse to give Resident #A another Xanax, to which the nurse refused, and then called the DON (Director of Nursing) to advise her of Resident #A not wanting to enter the facility. Nursing notes dated 9/26/14 at 6:30 p.m., indicated the daughters then asked if they (the daughters) took Resident #A out to eat and gave him his medications, could they come back and try again to get		activated. The vendor returned to the facility on10-03-14 and permanently wired the Emergency Egress switch to the door controller, which automatically locks the door and sounds alarm when a resident with a wander guard bracelet approaches the door. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the maintenance department staff have been in-serviced on how to check the door alarm system including the emergency egress function to ensure that the doors lock and the alarm sounds when a resident with a wander guard bracelet approaches the doors. The maintenance department has also been instructed that the Administrator is to be notified immediately if the system malfunctions in any manner. The facility will implement the visual monitoring of the door at that time until appropriate repairs are made. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a preventative maintenance log has been put in place to record the daily checking of the proper functioning of the door alarm system. This log will be completed daily by the maintenance department. The shifts and times will vary. Any malfunctions are to be	

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	Resident #A into the facility. To which the nurse indicated he would be welcomed, but he would have a code alarm (an elopement preventative monitor placed on either the wrist or ankle) placed due to being not accepting of placement. Review of nursing notes dated 9/26/14 at 8:30 p.m., indicated Resident #A returned to facility with their grandson and daughter. A wanderguard was placed on Resident #A stat (immediately) and family was aware. A wanderguard is a device to prevent elopement/exiting without staff's knowledge. This device, which is usually placed around an ankle, can trigger an alarm if the person wearing it gets too close to an exit, alerting staff to check exits immediately. Review on 11/10/14 at 3:40 p.m., of the admission elopement risk assessment dated 9/26/14, indicated on the 7:00 a.m. to 3:00 p.m., day shift sheet the resident was at risk for elopement, but not on the 3:00 p.m to 11:00 p.m., evening shift report. On 09/27/14 at 3:57 p.m.., a physician order was received to check placement of the wanderguard every shift and to check function weekly. Review of said physician order was noted and results		immediately reported to the Administrator for further action. The outcome of this maintenance log will be reviewed at the quarterly Quality Assurance meeting to determine if any additional action is warranted. Completion Date 10-03-14	

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	were noted on the TAR (Treatment Administration Record). Nursing notes dated 9/28/14 at 3:51 p.m., indicated Resident #A was a lot more calm today compared to yesterday and stayed in their room most of day. Wanderguard placement checks continued. Elopement risk assessments were completed as well as care plan related to behaviors, wandering and possible attempt at elopement. The care plan goal documentation dated 09/26/14, included but were not limited to: Goal: [Resident #A's name] will not succeed in elopement from the facility through the next 90 days. Preventions and interventions include, but were not limited to: "1) If [Resident #A's name] is observed attempting to leave the facility unescorted redirect [Resident #A's name] to a safe area. 2) Attempts to identify possible needs during periods of attempts to elope (i.e. thirst, pain, hunger, need to toilet , etc). 3) Be watchful and alert to potential signs of increased agitation i.e., change in volume and tone of voice, change in facial expressions, raising of hands, clenched fist, body language, etc and intervene by ensuring resident's safety by separating residents if needed). 4) Utilize fifteen (15) minute checks per facility policy. 5) Allow resident to call			

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	his family for reassurance of safety." Nursing notes dated 9/29/14 at 9:53 a.m., indicated at approximately 5:00 a.m. Resident #A was noted to be walking down the hall with belongings in his hands. At that time, nurse redirected Resident #A, informing him it was dark outside and he was only wearing non-skid socks, not shoes. Wanderguard was noted to be on the right ankle. Resident #A redirected and asked to stay with the staff. Resident #A chose to return to his room and placed the belongings on the bedside table in room. According to the continuation of above notes, a security breach was discovered at approximately 5:04 a.m., when a routine head count was not correct. It was found to be Resident #A was no where to be found. At that time all administrative personnel were called in, Resident #A's family were notified, and a full facility search was conducted in and outside the facility. The police were called and arrived at approximately 5:14 a.m. Approximately 5:45 a.m., Resident #A was brought back to the facility by a local citizen who found Resident #A near the entrance of the nearby cemetery. (Per odometer in this writer's car it is			

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	approximately 0.4 miles from the front door of the facility to the start of the cemetery's gravel road. There is one stop sign between the front door of the facility and the gravel road. This road appeared to be an old country side road with no traffic at the time mileage was gathered. Resident#A had 3 abrasions and skin tears 2 cm (centimeters) x 2 cm (centimeters) x 0.1 cm (centimeters). There was no drainage or active bleeding and the wounds were cleansed and covered. Resident #A tolerated well. Resident #A had a calm demeanor and no distress was noted. No complaints of pain or discomfort. Interviews with the ED (executive Director), ADM (Administrator), and Maintenance on 11/10/14 and 11/12/14, indicated Resident #A pushed right front door hard enough to open it, and the alarm did not go off. The ED indicated on 9/29/14, a local company, re-assessed the doors for the reason why Resident #A was able to go through the doors without the alarm sounding. The assessed doors were replaced in July of 2014. It was established that one of the switches, called the the Emergency Egress switch, was never tied in through the door			

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	controller, thus making the door to be able to be opened if someone pushed on it and the alarm would not go off as they passed through it. The ED further indicated it was found the system was not completely checked to ensure that it functioned properly when the new doors were placed in July of 2014. The facility investigation concluded Resident #A was not at the door long enough to set off the overhead page and just pushed on the door and continued out to the sidewalk. This Federal tag relates to Complaint IN00158834. 3.1-45(a)(1)			